TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
North Texas Pain Recovery Center

Respondent Name
Employers Insurance Co of WAUS

MFDR Tracking Number
M4-17-0874-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
December 1, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to Rule 134.202(4) "a maximum of 3 FCEs for each compensable injury shall be billed and reimbursable."

Amount in Dispute: $207.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have attached copies of the EOBs from the initial three FCE's. We do not show that any of these were part of designated doctor exam."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 30, 2016	97750	$207.92	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.225 sets out the reimbursement guidelines for functional capacity evaluations.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - M359 – Time expended on or the number of functional capacity evaluations has been exceeded
   - 193 – Time expended on or the number of functional capacity evaluations has been exceeded
   - X598 – Claim has been re-evaluated based on additional documentation submitted; no additional payment due

- W3 – Time expended on or the number of functional CAPA

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for Code 97750 rendered on August 30, 2016. The insurance carrier denied disputed services with claim adjustment reason code M359 – "Time expended on or the number of functional capacity evaluations has been exceeded."

   28 Texas Administrative Code §134.225 states,

   > The following applies to functional capacity evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the division shall not count toward the three FCEs allowed for each compensable injury.

   Review of the submitted information included:

   - Explanation of benefits for date of service January 8, 2015 for 97750 - FC, rendered to injured worker
   - Explanation of benefits for date of service February 2, 2015 for 97750 – FC, rendered to injured worker
   - Explanation of benefits for date of service July 6, 2015 for 97750 - FC, rendered to injured worker

   Per the above documentation, three FCEs were billed and reimbursed for this injured workers compensable injury. Therefore, the carrier's denial is supported.

2. Based on the requirements of Texas Administrative Code §134.225, the maximum number of FCEs was billed and reimbursed prior to the date of service in dispute. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 4, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.